Payment to Agency Report

A Public Document

PAYMENT TO AGENCY REPORT

California Form **801**

For Official Use Only

Date Stamp

1. Agency Name

California Health and Human Services

Division, Department, or Region (if applicable)

Department of Health Care Services

Street Address

1501 Capitol Avenue, Suite 6001

Area Code/Phone Number

Email

Agency Contact (name and title)

☐ **Amendment** (explain in comment section)

Date of Original Filing: 04/30/15 (month, day, year)

2. Donor Name and Address

☐ Individual _____ Last Name _____ First Name

☑ Other California Endowment and California HealthC Name

4800 2nd Avenue, Suite 2600 Address | Sacramento, City | CA State | 95817 Zip Code

Institute for Population Health Improvement

If "Other" is marked, describe the entity's business activity (if business) or its nature and interests.

→ If applicable, identify the name of each source and the amount(s) received by the donor for this payment:

Rene Mollow Name | $137.93 Amount | _____ Name | $_____ Amount

3. Payment Information (Complete Sections 3.1 (a or b), 3.2, 3.3)

3.1 (a) Travel Payment

Dallas, TX Location of Travel | 02/08-12/2015 Dates (month, day, year)

SouthWest Transportation Provider

☐ Rail ☑ Air ☐ Bus ☐ Auto ☐ Other Check Applicable Boxes

_____ Name of Lodging Facility

$_____ Lodging Expenses | $65.93 Meal Expenses | $72.00 Transportation Expenses | $_____ Other Expenses | $137.93 Total Expenses

3.1 (b) Payment(s) not related to travel:

_____ Dates (month, day, year) | $_____ Total Expenses

3.2. Payment Description. Provide a specific description of the payment and its agency purpose and use.

2015 National Organizations for State and Local Officials Advisory Group In-Person Meeting members lend their expertise to inform activities related to technical assistance work and state-to-state learning communities.

3.3. Identify the officials who used the payment in Section 3.1 (See instructions)

Last Name	First Name	Position/Title	Department/Division
Mollow	Rene	Deputy Director	Health Care Benefits & Eligil

4. Verification

I authorized the acceptance of the reported payment(s) as in compliance with FPPC regulations.

Signature | Karen Johnson Print Name | Chief Deputy Director Title | 4/30/2015 (month, day, year)

Comment:

(Use this space or an attachment for any additional information)

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